

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# 2699 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02685

Item 20d Film 193 3-12-56 et

Reg. Dist. No. 67

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>		c. LENGTH OF STAY IN 1b <u>Two</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10 Road Accident</u>		e. STREET ADDRESS <u>500 S. Longwood</u>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>J</u> Last <u>ADAMS</u>		4. DATE OF DEATH Month <u>MAR.</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-1909</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing Supply</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward F. Adams</u>		14. MOTHER'S MAIDEN NAME <u>Annie Browning</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-05-3026</u>	
17. INFORMANT <u>Mrs. Elva E. Adams</u> Address <u>BALTO. (23) 500 S Longwood St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Fractures, Internal Injuries - 816X</u> DUE TO (b) <u>2nd Degree Burns over entire body -</u> DUE TO (c) <u>Automobile Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident - 2 Trucks Collided</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11 3-2 1956</u> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway Rural Denton Caroline Md</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Notural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dawson George</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dawson George</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-5-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman Schuch</u> ADDRESS <u>BALTO (29) 3512 Fred. Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 5 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mrs. J. O. George</u>	

DATE SIGNED

3/2/56

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: \_\_\_\_\_  
 SEX: \_\_\_\_\_ AGE: \_\_\_\_\_  
 DATE OF DEATH: \_\_\_\_\_  
 PLACE OF DEATH: \_\_\_\_\_  
 CITY OF DEATH: \_\_\_\_\_  
 COUNTY OF DEATH: \_\_\_\_\_  
 STATE OF DEATH: \_\_\_\_\_  
 OCCASION OF DEATH: \_\_\_\_\_  
 CAUSE OF DEATH: \_\_\_\_\_  
 MANNER OF DEATH: \_\_\_\_\_  
 MEDICAL HISTORY: \_\_\_\_\_  
 PRESENT ILLNESS: \_\_\_\_\_  
 TREATMENT: \_\_\_\_\_  
 POST-MORTEM EXAMINATION: \_\_\_\_\_  
 FINDINGS: \_\_\_\_\_  
 SIGNATURE OF EXAMINER: \_\_\_\_\_  
 TITLE OF EXAMINER: \_\_\_\_\_  
 DATE OF EXAMINATION: \_\_\_\_\_

BUREAU V. S.

MAR 5 1956

RECEIVED

2700

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>LILLIAN</u> First <u>DAVIS</u> Middle <u>BARROW</u> Last				4. DATE OF DEATH Month <u>MAR</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1885</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTH PLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles P. Lockwood</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Chamberlain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>not</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>222 Maryland Walton Denton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular Renal Disease</u> DUE TO (c) <u>6 mcs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> 1955, to <u>Mar 12</u> 1956, that I last saw the deceased alive on <u>3/11</u> 1956, and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Denton Md</u> DATE SIGNED <u>3/12/56</u>							
ACTUAL SIGNATURE <u>Dawson O George</u>				M.D. <u>Denton Md</u>			
PHYSICIAN'S NAME (Type) <u>DAWSON O. GEORGE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar 13, 1956</u>		<u>Denton</u>		<u>Denton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Virgil Krosson</u> ADDRESS <u>Denton</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>3/12/56</u>		<u>Dawson O George</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

14 JAN 1956

RECEIVED

2701

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton, R. F. D.</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston, R. F. D.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alonzo L. Bridegroom</b>				4. DATE OF DEATH Month Day Year <b>March 26, 19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 20 1893</b>		9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mechanic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Bridegroom</b>				14. MOTHER'S MAIDEN NAME <b>Anna Rebecca Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>219-08-5825</b>		17. INFORMANT <b>Elwood Bridegroom, Preston, Md.</b> Address <b>R. F. D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidental Drowning</b> <b>929.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dawson O. George</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dawson O. George</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 15, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Linchester Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Preston, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Harvey Williamson</b>				ADDRESS <b>Federalburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5-14-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Dawson O. George</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
MAY 16 1956  
BUREAU V. S.

MAY 16 1956

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02688

2702

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Caroline</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Caroline</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Preston - Rural</i>		<i>Life</i>		OR TOWN <i>Preston - Rural</i> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Easton Road</i>				STREET ADDRESS (If rural give location) <i>Easton Road</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>William Orland Cheezum</i>				<i>March 7 1956</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>Sept. 23, 1891</i>	<i>64</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Farm Owner</i>		11. BIRTHPLACE (State or foreign country): <i>Caroline County, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME: <i>William H. Cheezum</i>				14. MOTHER'S MAIDEN NAME: <i>Martha E. Harding</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY No. <i>Unknown</i>		17. INFORMANT & ADDRESS: <i>Mrs. Florence E. Cheezum, Preston, Md. R.F.D.</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Acute Coronary Thrombosis</i>						<i>7 days</i>	
ANTECEDENT CAUSE (S) DUE TO (B) <i>Arteriosclerotic Heart Disease</i>						<i>7 5 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/1</i> , 19 <i>56</i> , to <i>3/7</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>3/4</i> , 19 <i>56</i> , and that death occurred at <i>6:30 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>D. H. B. Bunner</i>		ADDRESS <i>Preston, Md.</i>		DATE SIGNED <i>3/8/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>March 11, 1956</i>		NAME OF CEMETERY OR CREMATORY <i>Junior Order Cemetery</i>		LOCATION (City, town, or county) (State) <i>Linchester, Caroline Co. Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>3-9-56</i>		REGISTRAR'S SIGNATURE <i>Cornelia W. P. Bunner</i>		24. FUNERAL DIRECTOR <i>J. J. Frampton</i>		ADDRESS <i>Edison, Federalburg, Md.</i>	

BUREAU V. S.

MAR 12 1956

RECEIVED



2703

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>	
c. LENGTH OF STAY IN 1b <u>40 yrs</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE BEATRICE CORKRAN</u>		4. DATE OF DEATH Month Day Year <u>MAR 7 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1888</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Ball</u>		14. MOTHER'S MAIDEN NAME <u>Clara Waddell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Howard Corkran Denton, wid</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>2 years,</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchiolitis - acute Bronchitis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 24</u> , 19 <u>24</u> , to <u>Mar 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 6</u> , 19 <u>56</u> , and that death occurred at <u>5:05 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E Paul Knotts</u>		ADDRESS (Street, city or town, state) <u>Denton Md</u>	
PHYSICIAN'S NAME (Type) <u>E Paul Knotts</u>		DATE SIGNED <u>3-9-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Mar. 11, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Koverton</u>		ADDRESS <u>Denton, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 3-16-56</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. D. George</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>Baltimore, Md.</i>		5. DATE OF BIRTH <i>Jan 15, 1910</i>		6. TIME OF DEATH <i>10:30 AM</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF DEATH <i>Home</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		11. SIGNATURE OF REGISTRAR <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		15. SIGNATURE OF OTHER <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		18. SIGNATURE OF OTHER <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		21. SIGNATURE OF OTHER <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		24. SIGNATURE OF OTHER <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		27. SIGNATURE OF OTHER <i>John Doe</i>	
28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		30. SIGNATURE OF OTHER <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		33. SIGNATURE OF OTHER <i>John Doe</i>	
34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		36. SIGNATURE OF OTHER <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		39. SIGNATURE OF OTHER <i>John Doe</i>	
40. SIGNATURE OF DECEASED <i>John Doe</i>		41. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		42. SIGNATURE OF OTHER <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		45. SIGNATURE OF OTHER <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		48. SIGNATURE OF OTHER <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		51. SIGNATURE OF OTHER <i>John Doe</i>	
52. SIGNATURE OF DECEASED <i>John Doe</i>		53. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		54. SIGNATURE OF OTHER <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		57. SIGNATURE OF OTHER <i>John Doe</i>	
58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		60. SIGNATURE OF OTHER <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		63. SIGNATURE OF OTHER <i>John Doe</i>	
64. SIGNATURE OF DECEASED <i>John Doe</i>		65. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		66. SIGNATURE OF OTHER <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		69. SIGNATURE OF OTHER <i>John Doe</i>	
70. SIGNATURE OF DECEASED <i>John Doe</i>		71. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		72. SIGNATURE OF OTHER <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		75. SIGNATURE OF OTHER <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		78. SIGNATURE OF OTHER <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		81. SIGNATURE OF OTHER <i>John Doe</i>	
82. SIGNATURE OF DECEASED <i>John Doe</i>		83. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		84. SIGNATURE OF OTHER <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		87. SIGNATURE OF OTHER <i>John Doe</i>	
88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		90. SIGNATURE OF OTHER <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		93. SIGNATURE OF OTHER <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		96. SIGNATURE OF OTHER <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		99. SIGNATURE OF OTHER <i>John Doe</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		102. SIGNATURE OF OTHER <i>John Doe</i>	

RECEIVED  
MAR 12 1956  
BUREAU V. 3

## CERTIFICATE OF DEATH

02690

Reg. Dist. No. 64

2794

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>				c. LENGTH OF STAY IN 1b <u>2 yrs. 5mons.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>401 Academy Avenue</u>				d. STREET ADDRESS <u>401 Academy Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Michael</u> Last <u>Frasor</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 10, 1930</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Elks Nat. Commission</u>		11. BIRTHPLACE (State or foreign country) <u>Streeter, Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Francis Joseph Frasor</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Cochran</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>348-12-8140</u>		17. INFORMANT <u>Mrs. Lelah S. Frasor, Federalburg, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>286.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition</u> DUE TO (c) <u>CVA, Remote, &amp;</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular dis.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 10, 1954</u> to <u>Mar. 23, 1956</u> , that I last saw the deceased alive on <u>March 22, 1956</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Robert C. Kingsbury</u> M.D. <u>Federalburg, Maryland</u>				<u>March 24, 1956</u>			
PHYSICIAN'S NAME (Type) <u>Robert C. Kingsbury</u>				<u>Federalburg, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 26, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulcher Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Blue Island, Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton &amp; Son</u>				ADDRESS <u>Federalburg, Maryland</u>		24a. REC'D BY REGISTRAR <u>March 24, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>		<p>11. TIME OF DEATH</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF FUNERAL HOME</p>		<p>15. SIGNATURE OF WITNESSES</p>		<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF OTHER</p>	

BUREAU V. E.

MAR 27 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2705  
CERTIFICATE OF DEATH

02691

Reg. Dist. No. 61

1. PLACE OF DEATH o. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u>				c. LENGTH OF STAY IN 1b <u>60 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Alfred</u> Last <u>Hutson</u>				4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/26/1892</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Pet Milk Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John A. Hutson</u>				14. MOTHER'S MAIDEN NAME <u>Mollie E. Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-03-9479</u>		17. INFORMANT <u>Ida Hutson</u> Address <u>Greensboro, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-renal disease</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb. 1</u> , 19 <u>54</u> , to <u>Mar. 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 19</u> , 19 <u>56</u> , and that death occurred at <u>12:50M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u> DATE SIGNED <u>3/20/56</u> ACTUAL SIGNATURE <u>C. H. Stonesifer</u> M.D. PHYSICIAN'S NAME (Type) <u>C. H. Stonesifer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Bouleais</u>				ADDRESS <u>Greensboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3/22/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. MacPerrin</u>			

BUREAU V. S.

27 MAR 1958

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2706 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02692

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Caroline</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u> c. LENGTH OF STAY IN 1b <u>2 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u> d. STREET ADDRESS <u>None</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Georgia</u> Middle <u>Lee</u> Last <u>Kelley</u> <b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>20</u> Year <u>1956</u>				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1/8/56</u> <b>9. AGE</b> (In years last birthday) yrs. <u>2</u> Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u> <b>13. FATHER'S NAME</b> <u>George B. Kelley</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Norma Lee Dandy</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>George Kelley</u> Address <u>Denton, Maryland</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Oedema</u> DUE TO (b) <u>Influenza</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>o. m.</u> <u>19</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Dawson O. George</u> M.D. <b>EXAMINER'S NAME (Type)</b> <u>Dawson O. George M.D.</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>3-20-56</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3/22/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Mary's Hamden</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J.E. Boulaie's Greensboro, Md.</u> ADDRESS _____		<b>24a. REC'D BY REGISTRAR</b> <u>DATE 3/26/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Mrs. D. O. George</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 4 and 5 with the registrar prior to burial, cremation, or removal.

DEPARTMENT OF HEALTH-BALTIMORE 10

MAR 23 1956

[illegible]



BUREAU V. S.

MAR 16 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02694

## CERTIFICATE OF DEATH

Reg. Dist. No. 66

2708

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ridgely</u>		<u>55 yrs.</u>		TOWN <u>Ridgely</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 482</u>				STREET ADDRESS (If rural give location) <u>P.O. Box 482</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Walter</u> (Middle) <u>Mosley</u> (Last)				(Month) <u>3</u> (Day) <u>1</u> (Year) <u>1956</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Male</u>		<u>Col</u>		<u>Married</u>		<u>3/8/75</u>	
						<u>80</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<u>Farmer</u>				<u>Farm owner</u>		<u>Delaware</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Morris Mosley</u>				<u>Caroline Hansley</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
				<u>218-24-6135A</u>		<u>Mr. Wendie Mosley</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>443X</u> IMMEDIATE CAUSE (A)				<u>Cerebral Hemorrhage.</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Hypertensive Cardiovascular Disease -</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO				<u>Arterio Sclerosis, Generalized</u>			
STATING UNDERLYING CAUSE LAST, (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
				<u>6 hrs</u>			
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)				<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <u>Sept 1952</u>, to <u>March 1, 1956</u>, that I last saw the deceased alive on <u>March 1, 1956</u>, and that death occurred at <u>10:45 A.M.</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>Charles Herbert Winneft</u>				<u>Ridgely Maryland 3.1.56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>	
<u>Burial</u>				<u>3/15/56</u>		<u>Union Cemetery</u>	
						<u>Goldsborough, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
				<u>Mary C. Laird</u>		<u>James B. Bushnell, Easton, Md</u>	
<b>DATE</b>				<b>ADDRESS</b>			
<u>3/9/56</u>							

10030

U.S. DEPARTMENT OF HEALTH - BALTIMORE 18

# CERTIFICATE OF DEATH

5708

AT MEDICAL EXAMINATION OF DEATH

PLACE OF DEATH

MARYLAND

STATE OF

1918

DATE

DEATH

1918

1918

1918

1918

A230

1918

1918

IN MEDICAL EXAMINATION

IN MEDICAL EXAMINATION

BUREAU V. S.

MAY 9 1955

RECEIVED

1918

1918

1918

RECEIVED

U.S. DEPARTMENT OF HEALTH - BALTIMORE 18



2709

CERTIFICATE OF DEATH

03831

Reg. Dist. No.

61

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		c. LENGTH OF STAY IN TB <b>6 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>20X-2</b>	
3. NAME OF DECEASED (Type or print) First <b>Hulda</b> Middle <b>Parrott</b> Last <b>Parrott</b>		4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 29, 1870</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Edward Butler</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Butler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Family Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 4, 1955</b> , to <b>Mar. 31, 1956</b> , that I last saw the deceased alive on <b>March 31, 1956</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles H. Stonesifer</b> M.D.		ADDRESS (Street, city or town, state) <b>Greensboro, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>		DATE SIGNED <b>3/31/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>April 3, 56</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Easton Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Tuck</b>		ADDRESS <b>Easton, Md</b>	
24a. REC'D BY REGISTRAR <b>DATE 7/3/56</b>		24b. REGISTRAR'S SIGNATURE <b>L. M. Piggan</b>	

MEDICAL CERTIFICATION



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2710 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**02695**

Reg. Dist. No. **62**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Caroline</u> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u> c. LENGTH OF STAY IN 1b <u>hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>BALTIMORE</u> First <u>PERRY</u> Middle Last		<b>4. DATE OF DEATH</b> Month <u>MAR</u> Day <u>2</u> Year <u>1956</u>		<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>N</u>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Aug. 7, 1921</u>		<b>9. AGE</b> (In years last birthday) <u>34</u> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>plumbing</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>South Carolina</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>John Perry</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Spice Boulwell</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <u>John Perry Jr.</u> Address _____			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Fractures - Internal Injuries - Sudden</u> <u>816x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2nd Degree Burns over entire body</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Two Trucks Collided</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>11</u> a.m. <u>3-2</u> 19 <u>56</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>			
<b>20f. (City or town)</b> <u>Rural Denton</u>		<b>20g. (County)</b> <u>Caroline</u>		<b>20h. (State)</b> <u>MD</u>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Noturol causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <u>Dawson O. George</u>		<b>EXAMINER'S NAME (Type)</b> <u>DAWSON O. George</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. DATE SIGNED</b> <u>3-3-56</u>		<b>22b. DATE THEREOF</b> _____					
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Piney Grove Church</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Great Falls, So. Carolina</u> (State) _____					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Virgil Morrison</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE 3-3-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Mr. D. O. George</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAR 8 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please-remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

3855

## CERTIFICATE OF DEATH

03835

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Goldsboro</b>		c. LENGTH OF STAY IN 1b <b>77 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		d. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) <b>Frank</b> <b>Smith</b>		4. DATE OF DEATH Month <b>3</b> Day <b>30</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/2/1878</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Smith</b>		14. MOTHER'S MAIDEN NAME <b>Annie Klimer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-20-2581</b>	
17. INFORMANT <b>Alton Smith</b>		Address <b>Greensboro, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Mar. 30</b> , 19 <b>56</b> to <b>Mar. 30</b> , 19 <b>56</b> that I last saw the deceased alive on <b>Mar. 30</b> , 19 <b>56</b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles H. Stonesifer</b> M.D.		ADDRESS (Street, city or town, state) <b>Greensboro, Md.</b> DATE SIGNED <b>3/31/56</b>	
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/3/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>	22d. LOCATION (City, town, or county) (State) <b>Greensboro, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulais</b> <b>Greensboro, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4/5/56</b>	24b. REGISTRAR'S SIGNATURE <b>A. Clark Smith</b>

MEDICAL CERTIFICATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

APR 9 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2711 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02696

Reg. Dist. No. 66

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>		c. LENGTH OF STAY IN TB <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgely</u>				d. STREET ADDRESS <u>Ridgely</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ULRIC</u> <u>REICHMAN</u> <u>TOWERS</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 27, 1905</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JACOB Gardner Towers</u>		14. MOTHER'S MAIDEN NAME <u>Anita Reichman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs Ulric Towers</u>		Address <u>Ridgely, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (a), stating the underlying cause lost. DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dawson O. George</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dawson O. George MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3-21-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Virgil Moore</u>				24a. REC'D BY REGISTRAR DATE <u>Mar 21, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Laird</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		CITY [Faint text]	
COUNTY [Faint text]		STATE [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
PRESENT ILLNESS [Faint text]		HISTORY OF PRESENT ILLNESS [Faint text]	
PHYSICAL EXAMINATION [Faint text]		LABORATORY EXAMINATIONS [Faint text]	
POST-MORTEM EXAMINATION [Faint text]		OTHER INFORMATION [Faint text]	
SIGNATURE OF EXAMINER [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF SIGNATURE [Faint text]		TIME OF SIGNATURE [Faint text]	

RECEIVED  
 MAR 23 1956  
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2712

CERTIFICATE OF DEATH

02697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalburg</b>				c. LENGTH OF STAY IN 1b <b>full life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>none</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>none</b>				d. STREET ADDRESS <b>E. Central Ave.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter Trice</b>				4. DATE OF DEATH Month Day Year <b>March 4, 1956</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7, 1885</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>same</b>		11. BIRTHPLACE (State or foreign country) <b>Federalburg, R.F.D.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lewis Trice</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Stevenson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-05-3244</b>		17. INFORMANT Address <b>Mrs. Dora Trice Federalburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia with circulatory collapse</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anaplastic squamous cell carcinoma</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>191X</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  <b>18 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 15, 1944</b> , to <b>March 4, 1956</b> , that I last saw the deceased alive on <b>March 3, 1956</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>W. E. Lennon</b> M.D. <b>122 W. Central Ave. Federalburg, Md. 3/6/56</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>W. E. Lennon, M. D.</b> <b>Federalburg, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3/6/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey Williamson</b> <b>Federalburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>March 6, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Ernest Hutter, Deputy</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAR 9 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02698

2713

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>321 East Central Avenue</b>				e. STREET ADDRESS <b>321 East Central Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>James</b> Last <b>Turner</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 27, 1896</b>		9. AGE (In years last birthday) yrs. <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Alga J. Corkran</b>				14. MOTHER'S MAIDEN NAME <b>Aurelia Medford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>James R. Turner, Federalsburg, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous cell carcinoma</b> <b>191X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10/54</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/27/53</b> , 19____, to <b>3/18/56</b> , 19____, that I last saw the deceased alive on <b>3/17/56</b> , and that death occurred at <b>2:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Federalsburg, Maryland</b> DATE SIGNED <b>Mar. 19, 1956</b> ACTUAL SIGNATURE <b>W. E. Lennon</b> M.D. PHYSICIAN'S NAME (Type) <b>W. E. Lennon, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 20, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son</b> <b>Jerome Frampton, Jr.</b>				24a. REC'D BY REGISTRAR <b>DATE Mar. 19, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Margaret H. Frampton</b>	



CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>Male</b>		3. AGE <b>45</b>		4. DATE OF BIRTH <b>Jan 15, 1900</b>		5. PLACE OF BIRTH <b>Baltimore, Md.</b>		6. RACE <b>White</b>		7. OCCUPATION <b>Engineer</b>		8. MARITAL STATUS <b>Married</b>		9. DATE OF DEATH <b>Mar 18, 1956</b>		10. PLACE OF DEATH <b>Baltimore, Md.</b>		11. CAUSE OF DEATH <b>Heart Disease</b>		12. MANNER OF DEATH <b>Natural</b>		13. SIGNATURE OF PHYSICIAN <b>J. H. Smith</b>		14. SIGNATURE OF REGISTRAR <b>M. J. Jones</b>		15. SIGNATURE OF WITNESS <b>W. L. Green</b>		16. SIGNATURE OF DECEASED <b>John J. Brown</b>	
17. DISEASE OR INJURY <b>Myocardial Infarction</b>		18. PRESENTING SYMPTOMS <b>Chest pain, shortness of breath</b>		19. TIME OF ONSET <b>10:00 AM</b>		20. TIME OF DEATH <b>11:00 AM</b>		21. TIME OF EXAMINATION <b>12:00 PM</b>		22. TIME OF BURIAL <b>2:00 PM</b>		23. TIME OF CREMATION <b>3:00 PM</b>		24. TIME OF INTERMENT <b>4:00 PM</b>		25. TIME OF EXHUMATION <b>5:00 PM</b>		26. TIME OF REINTERMENT <b>6:00 PM</b>		27. TIME OF REINTERMENT <b>7:00 PM</b>		28. TIME OF REINTERMENT <b>8:00 PM</b>		29. TIME OF REINTERMENT <b>9:00 PM</b>		30. TIME OF REINTERMENT <b>10:00 PM</b>		31. TIME OF REINTERMENT <b>11:00 PM</b>		32. TIME OF REINTERMENT <b>12:00 PM</b>	
33. TIME OF REINTERMENT <b>1:00 PM</b>		34. TIME OF REINTERMENT <b>2:00 PM</b>		35. TIME OF REINTERMENT <b>3:00 PM</b>		36. TIME OF REINTERMENT <b>4:00 PM</b>		37. TIME OF REINTERMENT <b>5:00 PM</b>		38. TIME OF REINTERMENT <b>6:00 PM</b>		39. TIME OF REINTERMENT <b>7:00 PM</b>		40. TIME OF REINTERMENT <b>8:00 PM</b>		41. TIME OF REINTERMENT <b>9:00 PM</b>		42. TIME OF REINTERMENT <b>10:00 PM</b>		43. TIME OF REINTERMENT <b>11:00 PM</b>		44. TIME OF REINTERMENT <b>12:00 PM</b>		45. TIME OF REINTERMENT <b>1:00 PM</b>		46. TIME OF REINTERMENT <b>2:00 PM</b>		47. TIME OF REINTERMENT <b>3:00 PM</b>		48. TIME OF REINTERMENT <b>4:00 PM</b>	
49. TIME OF REINTERMENT <b>5:00 PM</b>		50. TIME OF REINTERMENT <b>6:00 PM</b>		51. TIME OF REINTERMENT <b>7:00 PM</b>		52. TIME OF REINTERMENT <b>8:00 PM</b>		53. TIME OF REINTERMENT <b>9:00 PM</b>		54. TIME OF REINTERMENT <b>10:00 PM</b>		55. TIME OF REINTERMENT <b>11:00 PM</b>		56. TIME OF REINTERMENT <b>12:00 PM</b>		57. TIME OF REINTERMENT <b>1:00 PM</b>		58. TIME OF REINTERMENT <b>2:00 PM</b>		59. TIME OF REINTERMENT <b>3:00 PM</b>		60. TIME OF REINTERMENT <b>4:00 PM</b>		61. TIME OF REINTERMENT <b>5:00 PM</b>		62. TIME OF REINTERMENT <b>6:00 PM</b>		63. TIME OF REINTERMENT <b>7:00 PM</b>		64. TIME OF REINTERMENT <b>8:00 PM</b>	
65. TIME OF REINTERMENT <b>9:00 PM</b>		66. TIME OF REINTERMENT <b>10:00 PM</b>		67. TIME OF REINTERMENT <b>11:00 PM</b>		68. TIME OF REINTERMENT <b>12:00 PM</b>		69. TIME OF REINTERMENT <b>1:00 PM</b>		70. TIME OF REINTERMENT <b>2:00 PM</b>		71. TIME OF REINTERMENT <b>3:00 PM</b>		72. TIME OF REINTERMENT <b>4:00 PM</b>		73. TIME OF REINTERMENT <b>5:00 PM</b>		74. TIME OF REINTERMENT <b>6:00 PM</b>		75. TIME OF REINTERMENT <b>7:00 PM</b>		76. TIME OF REINTERMENT <b>8:00 PM</b>		77. TIME OF REINTERMENT <b>9:00 PM</b>		78. TIME OF REINTERMENT <b>10:00 PM</b>		79. TIME OF REINTERMENT <b>11:00 PM</b>		80. TIME OF REINTERMENT <b>12:00 PM</b>	

RECEIVED  
MAR 21 1956  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2714 CERTIFICATE OF DEATH

02699

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Denton - Rural</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton - Rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>oo Near American Corner</b>				d. STREET ADDRESS <b>Near American Corner</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Kelly</b> Last <b>Turner</b>				4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 10, 1877</b>		9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Turner</b>				14. MOTHER'S MAIDEN NAME <b>Fannie (maiden name unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Roland D. Turner, Denton, Maryland, R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>8 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 18</b> , 19 <b>56</b> , to <b>March 9th</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>March 8th</b> , 19 <b>56</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. Paul Knotts M.D.</b>				ADDRESS (Street, city or town, state) <b>Denton, Maryland</b>		DATE SIGNED <b>March 12, 1956</b>	
PHYSICIAN'S NAME (Type) <b>E. Paul Knotts</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 12, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Concord Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son -</b>				ADDRESS <b>Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>3/12/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Margaret H. Frampton</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
HOME		MAY 1956	
DECEASED'S NAME		SEX	
JOHN DOE		M	
AGE		OCCUPATION	
45		Carpenter	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
DATE OF MARRIAGE		DATE OF BIRTH	
JAN 1940		MAY 1911	
PLACE OF BIRTH		CAUSE OF DEATH	
NEW YORK		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH	
MAY 1956		HOME	
DECEASED'S NAME		SEX	
JOHN DOE		M	
AGE		OCCUPATION	
45		Carpenter	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
DATE OF MARRIAGE		DATE OF BIRTH	
JAN 1940		MAY 1911	
PLACE OF BIRTH		CAUSE OF DEATH	
NEW YORK		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH	
MAY 1956		HOME	

BUREAU V. S.

MAR 14, 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02700  
62

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Caroline</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Queen Anne</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural-Denton</b>		c. LENGTH OF STAY IN 1b <b>traveling</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wye Mills</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>none</b>				d. STREET ADDRESS <b>none</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Elwood Grant Usilton</b>				<b>4. DATE OF DEATH</b> Month <b>Mar.</b> Day <b>2</b> Year <b>1956</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>Feb. 7, 1928</b>		<b>9. AGE</b> (In years last birthday) <b>28</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Freight Delivery</b>			
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Samuel Lewis Usilton</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ethel P. Moore</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service) <b>none</b>		<b>17. INFORMANT</b> Address <b>Mrs. Dolores N. Usilton, Wye Mills, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Muscle fracture, internal injuries</b>  <b>816X</b>  <b>DUE TO</b>  <b>(b) 2nd degree burns over entire body</b>  <b>DUE TO</b>  <b>(c)</b> </div> <div style="width: 15%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>Sudden</b> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Injury Caused</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>3-2 1956</b> Hour <b>11</b> a. m. <b>pm</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>			
<b>20f. (City or town)</b> <b>Rural Denton</b>		<b>20g. (County)</b> <b>Carroll</b>		<b>20h. (State)</b> <b>Md</b>			
<b>21. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/>, inspection <input checked="" type="checkbox"/>, inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>Amson O George</b> <span style="float: right;">M.D.</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>DAWSON O. George MD</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <b>3-2-56</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Mar. 6, 1956</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Spring Hill Cemetery</b>			
<b>22d. LOCATION</b> (City, town, or county) <b>Easton, Maryland</b>		<b>22e. (State)</b> <b>Md</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Thompson Carroll</b>				<b>ADDRESS</b> <b>Easton, Md.</b>			
<b>24a. REC'D BY REGISTRAR</b> <b>Mar 7 1956</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Mrs. S. O. George</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAR 8 1936

BUREAU V. S.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF DEATH: [illegible]  
5. PLACE OF DEATH: [illegible]  
6. CAUSE OF DEATH: [illegible]  
7. MANNER OF DEATH: [illegible]  
8. SIGNATURE OF EXAMINER: [illegible]  
9. SIGNATURE OF ATTENDING PHYSICIAN: [illegible]  
10. SIGNATURE OF CORONER: [illegible]

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural</b>		c. LENGTH OF STAY IN lb <b>full life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>none</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward Enos Williams</b>		4. DATE OF DEATH Month Day Year <b>March 14, 1956</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 11, 1879</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		12. KIND OF BUSINESS OR INDUSTRY <b>farming</b>	
13. BIRTHPLACE (State or foreign country) <b>Caroline Co. Md.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. FATHER'S NAME <b>Daniel Williams</b>		16. MOTHER'S MAIDEN NAME <b>Sarah Todd</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		18. SOCIAL SECURITY NO. <b>none</b>	
19. INFORMANT <b>Bennie H. Williams</b>		Address <b>Federalburg, Md.</b>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arterio sclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. _____ Month _____ Day _____ Year _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>April 14, 1957</b> , to <b>July 21, 1956</b> , that I last saw the deceased alive on <b>July 10, 1956</b> , and that death occurred at <b>7 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. Paul Knotts</b> M.D.		ADDRESS (Street, city or town, state) <b>Denton Md</b> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <b>E. Paul Knotts M.D.</b>		<b>Denton, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3/17/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Enos Williams</b> ADDRESS <b>Federalburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>March 17 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Margaret H. Thompson</b>			



CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
MAY 1956		BALTIMORE	
DECEASED'S NAME		SEX	
JENNIE M. WILLIAMS		F	
AGE		RACE	
78		WHITE	
MARRIED		OCCUPATION	
YES		HOUSEWIFE	
BIRTH DATE		BIRTH PLACE	
MAY 1878		MARYLAND	
FATHER'S NAME		MOTHER'S NAME	
JAMES T. WILLIAMS		MARY A. WILLIAMS	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
FARMER		HOUSEWIFE	
DECEASED'S ADDRESS		DECEASED'S CITY	
1234 E. BALTIMORE AVE.		BALTIMORE, MD.	
DECEASED'S STATE		DECEASED'S COUNTY	
MARYLAND		BALTIMORE	
DECEASED'S ZIP CODE		DECEASED'S DISTRICT	
21201		BALTIMORE	
DECEASED'S RELIGION		DECEASED'S ETHNIC ORIGIN	
METHODIST		WHITE	
DECEASED'S MARITAL STATUS		DECEASED'S EDUCATION	
MARRIED		HIGH SCHOOL	
DECEASED'S OCCUPATION		DECEASED'S SERVICE	
HOUSEWIFE		NONE	
DECEASED'S CAUSE OF DEATH		DECEASED'S MANNER OF DEATH	
HEART DISEASE		NATURAL	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS	
JENNIE M. WILLIAMS		1234 E. BALTIMORE AVE.	
DECEASED'S CITY		DECEASED'S STATE	
BALTIMORE		MARYLAND	
DECEASED'S COUNTY		DECEASED'S ZIP CODE	
BALTIMORE		21201	
DECEASED'S DISTRICT		DECEASED'S RELIGION	
BALTIMORE		METHODIST	
DECEASED'S ETHNIC ORIGIN		DECEASED'S EDUCATION	
WHITE		HIGH SCHOOL	
DECEASED'S MARITAL STATUS		DECEASED'S OCCUPATION	
MARRIED		HOUSEWIFE	
DECEASED'S CAUSE OF DEATH		DECEASED'S MANNER OF DEATH	
HEART DISEASE		NATURAL	

BUREAU V. S.

MAR 23 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02702

2717

## CERTIFICATE OF DEATH

Reg. Dist. No.

66

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Caroline</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>00</u>				d. STREET ADDRESS <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ANNIE</u> First <u>ELIZABETH</u> Middle <u>WOOTERS</u> Last				<b>4. DATE OF DEATH</b> Month <u>MAR</u> Day <u>7</u> Year <u>1956</u>			
<b>5. SEX</b> <u>7</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>JANUARY 24, 1869</u>	
				<b>9. AGE</b> (In years last birthday) <u>87</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	
<b>13. FATHER'S NAME</b> <u>Jesse F. Mitchell</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Anders</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				<b>17. INFORMANT</b> <u>Mrs Edwin Eaton, Ridgely, Md.</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio sclerosis -</u> DUE TO (c)						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>30 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
				<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that I attended the deceased from</b> <u>Jan 4</u> , 19 <u>49</u> , to <u>Mar 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 6</u> , 19 <u>56</u> , and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>E Paul Knotts</u> M.D.				<b>ADDRESS</b> (Street, city or town, state) <u>Denton Md</u> <b>DATE SIGNED</b> <u>3-4-56</u>			
<b>PHYSICIAN'S NAME</b> (Type) <u>E Paul Knotts</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Buried</u>		<b>22b. DATE THEREOF</b> <u>Mar 10, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenmount</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Hillbrow, Md.</u> (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Edgar Harrison</u> <b>ADDRESS</b> <u>Denton, Md.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>Mary E. Laird</u> <b>DATE</b> <u>3/10/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b>	

MEDICAL CERTIFICATION

